Australian Government
Department of Health, Disability and Ageing

Assignment of Medicare Benefits for Bulk Billing

Frequently Asked Questions

as at 27 August 2026

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Background

- Under the *Health Insurance Act 1973* (the Act), the Australian Government subsidises the cost of health services. This is the legal basis for Medicare benefits to be paid to patients. When patients direct their Medicare benefit payment to their healthcare health practitioner as full payment for a bulk-billed service, this requires an 'assignment of benefit' (AoB). In assigning their benefit, a patient is required to sign an agreement.
- During the COVID-19 pandemic, the Department of Health, Disability and Ageing (the department) issued temporary guidelines to support the AoB process for telehealth services. Under the temporary arrangements in certain situations, patients could verbally consent, as opposed to signing an agreement, to assign a benefit following their consultation with their doctor.
- In January 2023, the Australian National Audit Office released a report which noted that there could be legal risks with undertaking the AoB process verbally, without the requirement for the patient to sign. The Minister for Health, Disability and Ageing responded by asking the department to modernise the process of assigning benefits which will make it easier, safer, and more efficient for everyone.
- The Government has pursued legislative reforms to enable this for bulk billing and simplified billing of privately insured hospital and hospital-substitute treatment.
- Updated AoB requirements commenced on 1 July 2026. From this date, claiming forms from Services Australia have been updated to meet the requirements. This includes the DB4e and DB020 forms on the Services Australia website, and other DB manual claiming forms which will be available for stationery orders.
- An assignment of benefit agreement will need to contain the required information as per subsection 65C(4) of the Health Insurance Amendment Regulations 2018.
- AoB requirements outlined in this factsheet do not apply to patients accessing health care funded by the Department of Veterans' Affairs or under the Child Dental Benefits Scheme.

What are the changes?

The Australian Government has not introduced any new laws requiring patients to sign forms to access bulk billing under Medicare.

Patients have always needed to give permission for their Medicare benefit to be paid directly to their healthcare health practitioner when they are bulk billed. This means the health practitioner receives the Medicare payment and the patient does not have to pay for the service.

The changes that started on **1 July 2026** simply make it easier and more flexible for patients and Health practitioners to record this consent.

From 1 July 2026:

- Patients can provide their consent either before or after an appointment, as long as consent is obtained before the Medicare claim is submitted.

- Eligible patients can enter an enduring agreement, that covers future bulk-billed GP visits. This is available for:
    - patients registered with MyMedicare
    - residents of aged care homes
    - patients of Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services (AMSs).
- Health practitioners are no longer required to use a specific Medicare form to record patient consent. Health practitioners can use their own paper or electronic forms, provided they collect all information required by subsection 65C(4) and subsection 65D of the Health Insurance Amendment Regulations 2018 .
- Patients (or someone acting on their behalf) must still provide consent by signing either on paper or electronically. Electronic signatures must comply with the *Electronic Transaction Act 1999*.
- Health practitioners must keep a copy of the patient's consent record for 2 years and provide a copy if the patient asks for one.

These changes are designed to reduce administration and provide greater flexibility for patients and practices, while continuing to protect the integrity of Medicare.

Transitional arrangements have been made to support verbal assignment arrangements for bulk billed services until 30 June 2027. Where verbal assignment is used during the transitional period, providers should:

- record that the patient or assignor verbally agreed to assign the Medicare benefit
- retain a record of the assignment agreement and supporting documentation
- provide a copy of the assignment agreement to the patient or assignor if requested.

Why are the changes being made?

In 2023, the Australian National Audit Office released a report Expansion of Medicare Telehealth Services which identified potential legal risks associated with the use of verbal assignment and recommended that the process be strengthened.

In response, the Minister for Health, Disability and Ageing asked the department to modernise and simplify the Assignment of Benefit process across all bulk-billed Medicare services to make the process clearer, more consistent and easier to administer, while continuing to protect the integrity of Medicare.

To support these changes, the Government introduced a series of legislative reforms, including:

- The *Health Insurance Amendment (Assignment of Medicare Benefits) Act 2024* passed Parliament on 2 July 2024 and received Royal Assent on 9 July 2024.
- The *Health Legislation Amendment (Miscellaneous Measures No. 1) Bill 2025* passed Parliament on 30 October 2025 and received Royal Assent on 4 November 2025 for implementation on 1 July 2026.

These are supported by amendments to the Health Insurance Regulation 2018 made by the Governor-General at the following Executive Council meetings:

- On 21 August 2025, the Health Insurance Amendment (Assignment of Medicare Benefits and Other Measures) Regulations 2025.
- On 28 May 2026, the Health Insurance Amendment (Episodic Agreements and Simplified Billing Assignments) Regulations 2026.
- On 25 June 2026, the Health Insurance Amendment (Enduring Agreements) Regulations 2026.
- On 6 August 2026, the Health Insurance Amendment (Assignment of Medicare Benefits) Regulations 2026.

Where can I find more information?

For more information on the process of improving the assignment of benefit, please refer to: Improving the assignment of benefit process - Australian Government Department of Health, Disability and Ageing.

For enquiries or further details regarding the Assignment of Benefit (AoB) project, please reach out to: AssignmentofBenefit@health.gov.au

Introduction

Who is this guide for?

This guide is for anyone involved in bulk billing Medicare services, including:

- health practitioners across all specialties
- practice managers
- reception, administration staff and billing teams
- software vendors.

It explains how AoB works for bulk billed Medicare services from 1 July 2026.

What's in this guide?

The FAQs are grouped into the following sections:

1. **Transition to the new requirements** – key changes from 1 July 2026, transition arrangements and compliance expectations.
2. **Assignment of Benefit basics** – what an AoB is, who can assign a Medicare benefit, when an AoB is required, and who can act as an assignor.
3. **Forms and templates** – available forms and templates, using paper or electronic agreements, and transitional arrangements for practices not yet using digital solutions.
4. **Assignment requirements** – the information that must be included in episodic and enduring agreements, acceptable forms of agreement, and common implementation questions.
5. **Episodic agreements** – pre-service and post-service assignments, multiple services, changes to services or practitioners, and practical examples.
6. **Enduring agreements** – eligibility, required information, services that can be covered, when agreements start and end, and how the arrangements operate for MyMedicare patients, ACCHO/AMS patients and aged care residents.
7. **Special settings and scenarios** – applying AoB requirements in telehealth, residential aged care, home visits, public hospitals and other care settings.
8. **Pathology and diagnostic imaging** – transitional arrangements, request forms, and options for collecting AoB through integrated or separate agreements.
9. **Claims, software and implementation** – claiming processes, rejected or resubmitted claims, software readiness, electronic records, compliance, audits and practitioner responsibilities.
10. **Record keeping requirements** – retention of AoB agreements, supporting evidence, privacy obligations, and producing records when requested.

Note - The requirements described in this guide **do not apply** to:

- services funded by the **Department of Veterans' Affairs** (DVA), or
- services provided under the **Child Dental Benefits Schedule** (CDBS).

Existing claiming and consent arrangements continue to apply for these services.

Frequently asked questions

1. Transition to the new requirements

What is changing from 1 July 2026?

From 1 July 2026:

- patients can agree to be bulk billed before a service is provided (pre-service assignment) or after a service is provided (post-service assignment)
- health practitioners no longer need to use an approved Services Australia form
- AoB agreements can be paper-based or electronic
- health practitioners must retain completed agreements for 2 years
- eligible patients can enter into enduring agreements
- health practitioners no longer need to sign Assignment of Benefit agreements
- patients (or their assignor) must provide a physical or electronic signature unless transitional verbal arrangements apply.

What support is available during the transition period?

To support implementation:

- a 12-month transition period applies from 1 July 2026
- regulatory amendments have been made to support verbal assignment arrangements for bulk billed services until 30 June 2027
- a range of templates, forms and guidance materials have been published.

During the transition period, the Department's focus will be on education and helping Health practitioners understand the new requirements.

How will compliance be managed?

The Department will continue to take a risk-based approach to compliance.

During early implementation:

- education and support will be prioritised
- guidance materials will continue to be updated
- health practitioners are encouraged to adopt compliant processes as soon as practical.

2. Assignment of Benefit Basics

What is an assignment of benefit (AoB)?

An AoB is when a patient agrees to have their Medicare benefit paid to someone else instead of receiving the payment themselves.

How an AoB works depends on the type of claiming arrangement being used.

Bulk billing - the patient assigns their Medicare benefit to the health practitioner providing the service. The health practitioner receives the Medicare payment directly from Services Australia and accepts it as full payment for the service. This means:

- the patient does not pay for the service
- the health practitioner claims the Medicare benefit directly from Medicare
- the patient has no out-of-pocket cost for the service.

Example: A patient attends a GP clinic, specialist practice, allied health service or hospital outpatient clinic and is bulk billed. By completing an AoB agreement, the patient authorises Medicare to pay the Medicare benefit directly to the health practitioner.

Simplified billing - is used for eligible privately insured patients receiving hospital or hospital-substitute treatment. The patient assigns their Medicare benefit to their private health insurer, billing agent or the provider. This means:

- Medicare pays its share of the benefit to the other party
- the insurer manages both the Medicare and private health insurance components of the claim
- the patient does not need to submit a separate Medicare claim.

Example: A privately insured patient receives treatment in a private or public hospital. The patient assigns their Medicare benefit to the health insurer, allowing the insurer to receive the Medicare payment and process the claim on the patient's behalf. There may or may not be additional charges (‘gap payments’) depending on the practitioners’ fees.

Which health practitioners need to obtain a patient’s assignment of benefit?

Any health practitioner who intends to bulk bill a Medicare service must obtain a valid AoB before submitting the Medicare claim. This applies to Medicare services provided in:

- primary care and specialist clinics for any bulk billed services provided by any health practitioner, including Medicare services:
  - delivered in aged care settings, home visits or through telehealth;
  - like case conferencing where patients are not present, and
  - remote monitoring services such as ambulatory monitoring and sleep studies
- hospital settings – for any bulk billed services provided to private inpatients or outpatient by any health practitioner.

An AoB is only required when the service is being bulk billed.

If the patient is privately billed and pays for the service themselves, no AoB is required.

What is an AoB agreement?

An AoB agreement is a physical or electronic document that records a patient's agreement to assign their Medicare benefit. This is the legal basis for bulk billing under Medicare. It is an agreement between the patient (or another authorised person acting on the patient's behalf) and the health practitioner.

Through the agreement:

- the patient assigns their Medicare benefit
- the health practitioner agrees to accept that Medicare benefit as full payment for the service.

When a valid AoB agreement is in place:

- the Medicare benefit is paid directly to the health practitioner
- the health practitioner accepts that payment as full payment for the service
- the patient does not pay an out-of-pocket cost for the bulk-billed service.

From 1 July 2026:

- AoB agreements can be completed before or after a service is provided
- AoB agreements can be completed on paper or electronically
- there is no longer a requirement to use an approved government form, provided the agreement contains all required information.

There are two types of AoB agreement:

Episodic agreements

These cover a specific service or episode of care.

For example, a patient may complete an episodic agreement for a single consultation, procedure or course of treatment.

Enduring agreements

These allow eligible patients to assign Medicare benefits for ongoing services in specific circumstances, such as certain MyMedicare, ACCHO/AMS or residential aged care arrangements.

Health practitioners must keep a copy of completed AoB agreements and be able to produce them if requested as part of Medicare compliance, audit or verification activities.

Who is an ‘assignor’?

An assignor is the person who agrees to assign the Medicare benefit.

In most cases, the patient is the assignor.

However, another person may act on behalf of the patient in certain circumstances. Examples of people who may act as an assignor include:

- a parent assigning on behalf of a child
- a guardian
- a carer
- a partner
- a relative
- a person with power of attorney
- another responsible person acting on the patient's behalf.

Health practitioners should ensure that any person acting for a patient has appropriate authority to do so. Further information about who can act for a patient is available from Services Australia at Acting for someone with Medicare.

A treating practitioner or person employed by them or their practice should not act as the assignor, as this may be a conflict of interest.

At what age can a child make their own AoB agreement?

Generally, a child aged 14 years or older can make their own AoB agreement.

Children under 14 years of age will usually require a parent, guardian or other responsible person to complete the AoB on their behalf.

However, age is not the only consideration. In some circumstances, a child under 14 who has sufficient maturity and understanding to make their own healthcare and financial decisions may be able to enter into an AoB agreement themselves.

Where there is any uncertainty about a child's capacity to make their own decision, health practitioners should consider obtaining the AoB agreement from a parent, guardian or other authorised person and seek independent advice if necessary

For some enduring agreements, additional declarations may be required where another person is acting on behalf of a patient aged 14 years or older.

More information is available at What happens when your child turns 14 - Growing up - Services Australia

Is the assignor's name required?

- **For episodic agreements**, the assignor's name is not required information. Health practitioners may choose to record the assignor's name as part of their normal business and record-keeping processes.

  The agreement must identify whether the assignor is the patient (Yes/No) and include the assignor's signature or another valid form of agreement.

- **For enduring agreements**, where the assignor is not the patient, the agreement must record the assignor's name and their relationship to the patient (for example, parent, guardian, carer, attorney or another authorised representative). This helps establish the assignor's authority to act on the patient's behalf and provides a clear record of who entered into the agreement. It may be relevant for notifications in relation to services provided as part of the enduring agreement.

For an enduring agreement, if the patient is aged 14 years or over and another person is acting as the assignor (other than a Power of Attorney), additional patient declarations are also required.

What if a patient does not agree to assign their Medicare benefit?

If a patient does not assign their Medicare benefit:

- the service cannot be bulk billed
- the patient should be privately billed
- the patient may claim their Medicare benefit directly from Services Australia.

For unpaid or partially paid accounts, the 90 Day Pay Doctor Cheque Scheme may also be available.

3. Forms, templates and agreement requirements

Can I still use a DB4e or DB020 form?

Yes. From 1 July 2026, updated versions of these Services Australia forms can be used for episodic post-service Assignment of Benefit (AoB) agreements:

- DB4e - Bulk bill voucher - electronically transmitted claims form
- DB020 - Assignment of benefit Medicare bulk bill Webclaim form

Use of these forms is optional. Health practitioners may use their own paper or electronic AoB agreements, provided they contain all information required under the regulations.

If you need advice about which Services Australia form is appropriate for a specific claiming scenario, contact Services Australia on 132 011.

What templates are available?

The Department has published a range of optional templates, including:

Episodic agreements

- Episodic Pre-agreement (All MBS Services, excluding Pathology and DI)
- Episodic Pre-agreement (Diagnostic Imaging)

Enduring agreements

- MyMedicare Registered Patients
- Residential Aged Care Home Patients
- ACCHO and AMS Patients

Services Australia has also published updated DB4e and DB020 forms for episodic post assignment agreements.

Health practitioners may use these templates as published or modify them to suit their workflows or develop their own agreements.

The Department cannot approve or certify templates created by health practitioners.

What if our digital systems are not ready by 1 July 2026?

Digital solutions are not mandatory. Health practitioners may:

- use paper-based agreements, or
- use updated Services Australia forms or templates published by the Department, or
- develop their own compliant agreements.

Updated AoB requirements support both paper and electronic agreements, allowing practices to adopt the changes in a way that best suits their business needs and software systems.

Regardless of format, agreements must be retained for 2 years in hard copy or electronically.

Where do I send the completed AoB agreement?

A completed AoB agreement does not need to be sent to the Department of Health, Disability and Ageing or Services Australia.

As part of the provider's record-keeping obligations, the completed AoB agreement must be retained for 2 years from the date the claim is made and kept with the records supporting the Medicare claim.

If requested, the provider or practice should also provide a copy of the completed agreement to the assignor.

Copies of completed AoB agreements are only required to be submitted to Services Australia to support claims lodged manually.

Do I need to use a different template for verbal assignment?

No, the same optional templates can be used or you can create your own in accordance of section 65C, 65CA, and 65CB of the Health Insurance Regulations 2018. Where verbal assignment is used during the transitional period, providers should:

- record that the patient or assignor verbally agreed to assign the Medicare benefit
- retain a record of the assignment agreement and supporting documentation
- provide a copy of the assignment agreement to the patient or assignor if requested.

Practices must retain records of the assignment agreement for 2 years from the date the Medicare claim is made and provide a copy to the patient or assignor if requested.

4. Assignment requirements

What information must be included in an Episodic assignment agreement?

All assignment agreements must contain the information required under the regulations.

For episodic agreements, the required information differs slightly between:

- pre-service assignments
- post-service assignments

The table below outlines the information that must be included in an episodic pre-service or post-service AoB agreement.

For an assignment to be valid, all seven required data elements must be recorded. It is the provider's responsibility to ensure the agreement contains all required information.

One of these data elements records whether the assignor is the patient (Yes/No). The assignor is the person who agrees to assign the Medicare benefit. In some cases, this may be someone acting on the patient's behalf. For example, where the patient is a child under 14 years of age, the assignor would typically be a parent or other responsible adult.

Before the Medicare claim is submitted, the patient (or assignor) must be provided with a copy of the completed agreement, either electronically or in hard copy, and asked to sign it to confirm their agreement to assign the Medicare benefit to the provider.

For more detailed information, refer to section 65C of the *Health Insurance Regulations 2018*.

Assignment Type	Pathology (excluding Group 9)	Diagnostic Imaging	All other MBS services (including Group P9)
Pre-assignment	• Patient name • Date of assignment • Assignment type (pre-assignment) • Is the assignor the patient – yes/no • Date of specimen collection • Statement of assignor's agreement* • Description of the service	• Patient name • Date of assignment • Assignment type (pre-assignment) • Is the assignor the patient – yes/no • Date of imaging procedure • Statement of assignor's agreement (R type services)# • Description of the service	• Patient name • Date of assignment • Assignment type (pre-assignment) • Is the assignor the patient – yes/no • Details of the professional • Date of service • Basic service description
Post-assignment	• Patient name • Date of assignment • Assignment type (post-assignment) • Is the assignor the patient – yes/no • Date of specimen collection • Details of the professional (per Section 54 of the HIR) • MBS item/s	• Patient name • Date of assignment • Assignment type (post-assignment) • Is the assignor the patient – yes/no • Date of imaging procedure • Details of the professional • MBS item/s	• Patient name • Date of assignment • Assignment type (post-assignment) • Is the assignor the patient – yes/no • Details of the professional • Date of service • MBS item/s

* statement captures pathologist determinable services
# statement captures DI services as per Section 16B of the HIA (i.e. services deemed required by rendering health practitioner

What information must be included in an Enduring agreement?

The table below sets out a high-level overview of the information required for an enduring agreement. For more detailed information, refer to section 65CB of the Health Insurance Regulations 2018.

Requirement	MyMedicare	ACCHO / AMS	Residential Aged Care Home
Patient name	✓	✓	✓
Whether the assignor is the patient (Yes/No)	✓	✓	✓
Name of assignor (where not the patient)	✓	✓	✓
If applicable, relationship of assignor to patient (parent, guardian, attorney etc.)	✓	✓	✓
If applicable, patient declaration where patient is 14 years or older and another person is acting as assignor	✓	✓	✓
Signature (electronic or physical) of assignor	✓	✓	✓
Date agreement entered into	✓	✓	✓
Description of health practitioner services covered by agreement (e.g. using MBS Category; Group; Subgroup; or Item/s, or a combination)	✓	✓	✓
Information on how the agreement can be terminated	✓	✓	✓
Method by which notifications will be provided to assignor	✓	Not required	Not required
Name of health practitioner or authorised agent	✓	Name of authorised agent	✓
Practice address or health practitioner number	✓	Practice address or health practitioner number of agent	✓

How do I choose the right AoB agreement?

The most appropriate AoB agreement will depend on the type of service being provided, whether the service details are known in advance, and whether the patient is eligible for an enduring agreement.

As a guide:

Use an episodic pre-service agreement when:

- the patient agrees to be bulk billed before the service is provided
- the service to be provided can likely be predicted in advance
- your practice wants to obtain the patient's agreement during booking, registration or check-in.

An episodic pre-service agreement can also cover multiple planned services over a period of up to six months, provided the service dates, practitioner and services are known in advance.

Use an episodic post-service agreement when:

- the details of the service are not known until after the consultation
- the service provided differs from what was originally booked
- a pre-service agreement was not obtained
- the service ultimately falls outside the scope of an existing pre-service agreement.

For many practices, a post-service agreement may align more closely with existing workflows and billing processes.

Use an enduring agreement when:

- the patient is eligible for an enduring agreement
- the patient receives ongoing bulk-billed GP services
- both the patient and provider want a single agreement to cover future eligible services.

Enduring agreements are available for GP services provided to the following eligible patients:

- patients registered with MyMedicare
- residents of residential aged care homes
- patients of Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services (AMSs).

If you are unsure which agreement to use, consider when the patient's consent will be obtained and whether the services can be identified in advance. In most cases, this will help determine the most appropriate type of AoB agreement.

Can health practitioners use more than one type of agreement?

Yes. Health practitioners are not required to use the same approach for all patients or services. For example, a practice may:

- use episodic pre-service agreements for services where consent is obtained before the appointment

- use episodic post-service agreements where service details are not known until after the consultation
- offer enduring agreements to eligible patients receiving ongoing bulk-billed GP care.

Health practitioners can also adjust their approach over time as their business needs, workflows and software systems change.

Where an enduring agreement is in place, health practitioners are expected to continue using it for services covered by the agreement until it is terminated. If a health practitioner wishes to stop using an enduring agreement or change the services covered by it, the agreement must first be terminated in accordance with the legislative requirements.

A notice period must be provided before the termination takes effect. If the patient and health practitioner wish to continue using an enduring agreement under revised arrangements, a new enduring agreement will need to be entered.

What is an acceptable signature?

Patients, or someone acting on their behalf (the assignor), must provide evidence that they agree to assign their Medicare benefit. This can be done using either a physical signature or an electronic signature. Health practitioners are not required to sign the agreement.

To be valid, an electronic signature must:

- identify the person making the assignment (the assignor)
- indicate that the assignor agrees assign their Medicare benefit
- comply with applicable privacy obligations and the requirements of Section 10 of the *Electronic Transactions Act 1999* (ETA).

The *ETA* does not prescribe a specific type of electronic signature. Depending on the circumstances, acceptable methods may include:

- signing on a tablet or touchscreen or signature pad
- typing a name into an electronic form
- selecting an "I accept" or similar checkbox
- using a secure digital signature platform.

The most appropriate method will depend on the circumstances. Health practitioners should ensure that their chosen process can reliably identify the assignor and clearly record their agreement to assign their Medicare benefit.

Practices may wish to consult their software vendor about the functionality and compliance of any electronic signing solution. Independent legal advice should be sought where required. Additional guidance on electronic signatures is available from the Attorney-General's Department.

Is sending a text message and receiving a reply of YES sufficient?

Potentially. The *Electronic Transactions Act 1999* does not prescribe a specific type of electronic signature. An electronic signature may be valid if the method:

- identifies the person making the assignment (the assignor)
- shows the assignor's intention to agree to the assignment
- is sufficiently reliable for the purpose

For example, a health practitioner may send the required AoB information to a patient by text message and ask them to reply "YES" to confirm their agreement.

Whether this approach is sufficient will depend on whether the health practitioner can demonstrate:

- who provided the response
- what information was provided to the assignor before they responded
- that the response clearly indicated the assignor’s agreement to assign their Medicare benefit
- that a reliable and auditable record of the interaction has been retained.

Health practitioners are responsible for ensuring that the processes they use meet legislative requirements and support compliance, record-keeping and audit obligations. Practices may wish to consult their software vendor about the functionality of their systems and seek independent legal advice where appropriate.

What information must be included in a verbal agreement?

The information is the same as the episodic or enduring assignment agreements. However, where verbal assignment is used during the transitional period, providers should:

- record that the patient or assignor verbally agreed to assign the Medicare benefit
- retain a record of the assignment agreement and supporting documentation
- provide a copy of the assignment agreement to the patient or assignor if requested.

Can I use Medicare Easyclaim?

Yes. Medicare Easyclaim remains a valid way to obtain an AoB agreement.

When using Easyclaim, the patient assigns their Medicare benefit to the health practitioner by confirming the assignment through the EFTPOS terminal as part of the claiming process. This confirmation is treated as an electronic signature and satisfies the requirement for the patient to agree to the AoB.

Health practitioners can continue to use Medicare Easyclaim as part of their existing claiming and billing processes.

For more information about using Easyclaim, refer to the Services Australia guidance on submitting bulk bill claims using Medicare Easyclaim.

What if a patient cannot assign?

If a patient is unable to assign their Medicare benefit themselves, another person (the assignor) may be able to do so on their behalf. Examples include:

- a parent or guardian acting for a child
- a person holding power of attorney
- a legally appointed guardian

- another person authorised to act on the patient's behalf.

Where a patient lacks legal capacity or requires someone to act on their behalf for Medicare matters, health practitioners should refer to Services Australia's guidance on acting for someone with Medicare.

As a general principle, the person providing the assignment must have the authority to act on the patient's behalf and agree to assign the Medicare benefit to the health practitioner.

Furthermore, transitional verbal assignment arrangements are available until 30 June 2027.

Can an AoB agreement be amended after it has been completed?

No. An AoB agreement should be completed accurately before it is signed or otherwise agreed to by the patient or assignor.

If information needs to be changed—such as:

- who is assigning the Medicare benefit
- the health practitioner providing the service
- the service/s covered by the agreement

a new AoB agreement should be sought.

For pre-service episodic agreements, a new AoB agreement is required if the basic service description differs from the basic service description specified by the original agreement. A compliant post-service AoB agreement should be obtained before a Medicare claim can be submitted.

5. Episodic assignment agreements

How does episodic pre-service assignment work?

Patients can assign their Medicare benefit before receiving a service. This allows the patient's agreement to be obtained and recorded before the appointment takes place.

Common examples include:

- online booking systems
- appointment confirmation processes
- check-in kiosks
- reception check-in workflows.

When using a pre-service assignment, the agreement must describe the expected service using the relevant basic service description.

What if the service changes after a pre-service assignment?

A pre-service assignment remains valid if the service provided is within the agreed basic service description category. If the service provided is outside what was agreed, a new assignment will be required before the Medicare claim is submitted.

This can be completed as a post-service assignment after the service has been provided.

What if the health practitioner changes?

If the health practitioner who provides the service is different from the health practitioner identified in the agreement, a new assignment will be required.

This can be completed as either:

- a new pre-service assignment before the service is provided, or
- a post-service assignment after the service has been provided and before the Medicare claim is submitted.

Can one assignment cover multiple services?

Yes. A single AoB agreement can cover multiple services, provided the services are rendered by the same health practitioner and all other legislative requirements are met.

Where services are provided by more than one health practitioner, separate assignments will be required for each health practitioner.

Practices should ensure that the health practitioner identified in the agreement matches the health practitioner who delivers the service. If this changes, a new AoB agreement should be obtained.

Can pre-assignments cover future planned treatment?

Yes. An episodic pre-service Assignment of Benefit (AoB) agreement can cover multiple planned services over a period of up to six months, provided all relevant details are known in advance. This includes:

- the health practitioner who will provide the services
- the dates the services will be delivered
- the services to be provided.

This means a patient can complete a single AoB agreement for a series of planned appointments, rather than completing a separate agreement for each visit. Examples may include:

- dialysis treatment
- chemotherapy or other cancer treatment programs
- palliative care services
- other regular, scheduled healthcare services.

If any of the details covered by the agreement change, such as the service date, the type of service provided or the health practitioner delivering the service, a new AoB agreement will be required.

If more than one practitioner is involved in delivering the service, separate AoB agreements will be required for each practitioner and be specific to the service each health practitioner delivers.

How long is an episodic assignment valid for?

An episodic pre-assignment can be valid for services scheduled up to 6-months in advance. There is no limit on a post-assignment agreement, although providers must claim any assigned benefits from a bulk billed service within one year of rendering the service.

In either case, the agreement remains valid until it has been used (i.e. claimed) for the service or services covered by the agreement.

An episodic assignment is not intended to operate indefinitely or to cover future services that are not described in the agreement. If a patient receives additional services that are not covered by the original episodic assignment, a new AoB agreement may be required before those additional services can be claimed as bulk billed.

Can an episodic assignment be used for services provided on different days?

An episodic assignment can cover more than one service where those services are included in the same episode of care and are clearly described in the agreement. In some cases, the covered services may be provided on different days.

However, a single episodic assignment can only assign benefits to one provider. A single agreement for multiple services would need to be from the same provider, or multiple agreements would need to assign to different providers for their services.

An agreement cannot be used to cover future services that were not contemplated when the agreement was made. If additional services fall outside the scope of the original agreement, a new AoB agreement may be required.

What happens if the patient does not attend the appointment after signing a pre-service agreement?

If a patient signs or agrees to a pre-service episodic assignment but the service is never provided, the assignment cannot be used to support a Medicare claim because no Medicare-claimable service has been rendered.

The agreement may be retained as part of the practitioner's records, but no Medicare benefit can be claimed unless the service is provided. If the patient later attends for a different service, the health practitioner should ensure a valid AoB agreement exists for the service that is ultimately provided.

Can one episodic agreement cover services provided by multiple practitioners?

No. An episodic AoB agreement is linked to the health practitioner identified in the agreement. If a different practitioner provides the service, the original AoB agreement will no longer meet the requirements for assigning the Medicare benefit.

Health practitioners should ensure the AoB agreement accurately identifies the practitioner providing the service and contains all information required under the Health Insurance Regulations 2018.

6. Enduring agreements

What is an enduring agreement?

An enduring agreement allows eligible patients to assign their Medicare benefits for ongoing bulk-billed GP services without needing to complete a new Assignment of Benefit (AoB) agreement for every visit.

This can make ongoing care simpler for both patients and health practitioners by reducing paperwork and administrative steps.

Unlike an episodic agreement, which applies to a specific service or episode of care, an enduring agreement allows Medicare benefits to be assigned for future services covered by the agreement.

Who can enter an enduring agreement?

Enduring agreements are only available for eligible patients receiving GP services. The following patients may be eligible:

- patients registered with MyMedicare
- patients of Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services (AMSs)
- patients in residential aged care homes.

What information must be included?

An enduring agreement must include:

- patient details
- assignor details (if someone is acting on the patient's behalf)
- the scope of services covered by the agreement
- the patient's or assignor's signature
- the date the agreement was entered into
- information about how the agreement can be terminated
- the health practitioner's details.

Additional requirements may apply where someone is signing on behalf of a patient aged 14 years or older.

What services can be covered by an enduring agreement?

The services covered by an enduring agreement depend on the type of agreement and the patient's eligibility.

MyMedicare patients - An enduring agreement can cover eligible GP services provided by the GP named in the agreement at the patient's registered MyMedicare practice. Examples include:

- GP consultations
- telehealth consultations
- chronic disease management services

- care planning services
- other Medicare-funded GP services provided by the named GP.

ACCHO or AMS patients - An enduring agreement can cover Medicare-funded services provided by practitioners employed by the ACCHO or AMS. Examples include services provided by:

- GPs
- nurses and nurse practitioners
- Aboriginal Health Practitioners
- Aboriginal Health Workers
- allied health practitioners
- other eligible healthcare practitioners.

Residential aged care residents - An enduring agreement can cover Medicare-funded services provided by the GP named in the agreement. Examples include:

- GP consultations
- telehealth consultations
- after-hours services
- chronic disease management services
- other eligible Medicare-funded GP services.

How can an enduring agreement end?

An enduring agreement can end in several ways.

An enduring agreement may be terminated by the patient, the assignor (where applicable) or the health practitioner by providing written notice. Where a health practitioner gives notice to terminate an enduring agreement, the termination takes effect two business days after the notice is given.

An enduring agreement will automatically cease if:

MyMedicare patients

- the patient is no longer registered with MyMedicare
- the GP named in the agreement is no longer registered with MyMedicare at that practice
- the GP no longer practises at the agreed location using the relevant provider number.

ACCHO or AMS patients

- the patient is no longer a patient of the ACCHO or AMS
- the patient enters into certain other enduring agreements that are inconsistent with the ACCHO/AMS arrangement.

Residential aged care residents

- the patient is no longer a resident of a residential aged care home.

Once an enduring agreement ends, it can no longer be used and a new agreement will be required if the patient wishes to continue using an enduring arrangement.

How can an enduring agreement be drafted to cover all GP services?

An enduring agreement must clearly describe the services it covers. The description does not need to list every Medicare item number individually. Services can be described by reference to:

- MBS categories
- MBS groups
- MBS subgroups
- specific item numbers
- a combination of these.

If health practitioners want their agreement to cover most GP Medicare Benefits Schedule (MBS) items, they could either:

- include a detailed list of specific MBS items (for example, those covered by the Bulk Billing Practice Incentive Program (BBPIP)); or
- use a simpler approach by listing the relevant MBS Groups and Subgroups instead, such as "Total GP Non-Referred Attendances":
  - GROUP(S) - A01, A02, A05, A06, A07, A11, A14, A16, A17, A18, A19, A20, A22, A23, A27, A30, A34, A35, A39, A41, A42, A43, A45, A46
  - SUBGROUP(S) - A1501, A3601, A3604, A4001, A4002, A4003, A4010, A4011, A4012, A4013, A4014, A4015, A4016, A4019, A4020, A4021, A4022, A4027, A4028, A4029, A4030, A4039, A4040, A4041, A4401, A4402, A4403, A4404, A4405, A4406
  - ITEM(S) - 735, 739, 743, 747, 750, 758, 930, 933, 935, 937, 943, 945, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035, 5036, 5042, 5044, 17600, 90264, 90265, 92170, 92171, 92176, 92177

Health practitioners should carefully consider which services are included. Any service within the agreed scope must be bulk billed while the enduring agreement remains in effect. If the scope needs to change, the existing agreement should be ended and a new agreement entered.

Can one enduring agreement be used for services provided by different practitioners?

MyMedicare patients – No, a MyMedicare enduring agreement is linked to a specific GP and the patient's registered MyMedicare practice. If the patient sees a different GP, a separate enduring agreement is generally required for that GP.

ACCHO/AMS patients – Yes, a single enduring agreement can cover services provided by practitioners employed by the ACCHO or AMS from time to time. This means the agreement can continue to apply if the patient sees different healthcare practitioners within the same ACCHO or AMS.

Residential aged care residents – No, an aged care enduring agreement applies to the GP identified in the agreement. If services are provided by a different GP, a separate enduring agreement may be required.

What happens if the patient changes practices?

MyMedicare patients – If the patient changes to a different MyMedicare practice, the enduring agreement ceases and a new agreement will be required.

ACCHO/AMS patients – Patients of ACCHOs/AMSs can have multiple agreements across different organisations they visit for their care, although if the patient is no longer a patient of the ACCHO or AMS covered by the agreement, the agreement ceases. A new agreement may be entered into with another ACCHO or AMS.

Residential aged care residents – Moving to another aged care home does not automatically end the agreement. However, a new agreement may be needed if services are no longer provided by the practitioner or at the locations covered by the agreement.

Can an enduring agreement be suspended and later resumed?

No. The legislation does not provide a mechanism to suspend and later reactivate an enduring agreement. If an enduring agreement ends or ceases to operate, a new agreement will be required.

How should patients be notified about services claimed under an enduring agreement?

Notification requirements differ depending on the type of enduring agreement.

MyMedicare patients - The enduring agreement must specify the method by which written notifications will be provided to the assignor.

Where a responsible person enters into the agreement on behalf of a patient who is aged 14 years or older, the patient must provide a declaration confirming that they understand notifications will be sent to the assignor after services are rendered and that they agree to those notifications being sent.

ACCHO/AMS patients - The Regulations do not create a post-service notification requirement for ACCHO/AMS enduring agreements.

Residential aged care residents - The Regulations do not create a post-service notification requirement for residents in aged care homes.

When do providers needs to send post service notifications and what do these need to include?

Post-service notifications are only required for MyMedicare enduring agreements. Health providers must notify the assignor each time a Medicare claim is made under the enduring agreement, and any corrections to that claim notification must also be provided. Notifications must be sent:

- within 24 hours of submitting the Medicare claim; and
- within 24 hours of becoming aware of an error in a previous notification.

Post service notifications must include the following information:

- the name of the practitioner
- the name of the patient who received the service
- the date the service was provided
- the amount of Medicare benefit claimed.

Notifications must be provided in writing, include the date of the notification, and be sent using the method agreed to by the assignor (for example, email or SMS). Providers should clearly specify in the enduring agreement how post-service notifications will be sent, so the assignor is aware of and able to receive notifications using the nominated method.

Providers must retain a copy of the enduring agreement, any records of consent where applicable, copies of notifications issued under the enduring agreement, and any notice terminating the agreement for two years.

7. Special settings and scenarios

How do AoB arrangements apply to patients in aged care homes?

The same AoB requirements apply to services provided in residential aged care homes as in other settings. Patients, or an assignor acting on behalf of the patient, may assign their Medicare benefit using an approved assignment method.

An episodic AoB agreement may be obtained through:

- a paper-based agreement signed by the patient or assignor
- an electronic agreement signed by the patient or assignor
- verbal assignment during the transitional arrangements.

Eligible patients may also enter into an enduring assignment agreement for ongoing bulk-billed GP services. An enduring assignment allows a patient to provide a single assignment that applies to future eligible bulk-billed GP services, rather than completing a separate episodic AoB agreement for each consultation. An enduring assignment:

- is voluntary and can only be used where the patient meets the eligibility requirements
- allows the patient to assign Medicare benefits for future eligible bulk-billed GP services covered by the agreement
- reduces the need for repeated completion of episodic AoB agreements for each eligible service
- does not prevent the patient from withdrawing or varying the arrangement in accordance with the applicable requirements.

Where verbal assignment is used during the transitional period, providers should:

- record that the patient or assignor verbally agreed to assign the Medicare benefit
- retain a record of the assignment agreement and supporting documentation
- provide a copy of the assignment agreement to the patient or assignor if requested.

Practices must retain records of the assignment agreement for 2 years from the date the Medicare claim is made and provide a copy to the patient or assignor if requested.

Eligible patients may also enter into an enduring assignment agreement for ongoing bulk-billed GP services where the requirements for enduring assignment are met.

How do the arrangements apply in public hospitals?

Public patients should not be billed using the Medicare Benefits Schedule.

Where a patient elects to be treated as a private patient, standard Medicare and AoB requirements apply to any bulk-billed services for which Medicare benefits are payable.

In these circumstances:

- assignment must be obtained using an episodic AoB agreement. This can occur:
  - before the service is provided (pre-service assignment), or
  - after the service is provided (post-service assignment).

- a patient, or their assignor, may complete the episodic AoB agreement using:
  - a paper-based agreement
  - an electronic agreement
  - verbal assignment during the transitional period.
- where verbal assignment is used, the provider should:
  - record that the patient or assignor verbally agreed to assign the Medicare benefit
  - retain a record of the assignment agreement and supporting documentation
  - provide a copy of the assignment agreement to the patient or assignor if requested.
- the assignment must be completed before the Medicare claim is submitted.
- the provider must retain the assignment agreement and any supporting documentation for 2 years from the date the Medicare claim is made

Hospital administrators should ensure local billing processes clearly distinguish between public-patient and private-patient billing arrangements.

How do the arrangements apply to telehealth services?

The same AoB requirements apply to telehealth services as to face-to-face consultations. Assignment may be obtained either before the consultation (pre-service assignment) or after the consultation (post-service assignment), provided the assignment is completed before the Medicare benefit is claimed.

For telehealth services, providers may obtain assignment through:

- an electronic signature captured through a patient portal, online form or practice management system
- a paper agreement that is completed and returned electronically
- verbal assignment during the transitional period, where permitted.

Episodic Pre-service assignment

Where assignment is obtained before the consultation, the agreement must include the required information relating to the anticipated service, including a sufficient description of the service to be provided. If the service ultimately provided is not consistent with the description in the assignment agreement, a new assignment may be required before the Medicare claim is submitted.

Episodic Post-service assignment

Where assignment is obtained after the consultation, the agreement must reflect the service that was provided and include any information required for a post-service assignment, including the relevant MBS item number(s) where applicable.

Verbal assignment during the transition period

During the transitional period, where verbal assignment is used, providers should:

- record that the patient or assignor verbally agreed to assign the Medicare benefit
- retain a record of the assignment agreement and supporting documentation
- retain those records for 2 years from the date the claim is made
- provide a copy of the assignment agreement to the patient if requested.

Practices should ensure their telehealth workflows support the creation, completion, storage and retrieval of Assignment of Benefit records in the same way as face-to-face consultations, including the ability to produce assignment records if requested for compliance or audit purposes.

How do the arrangements apply to home visits?

A home visit can be bulk billed using either an episodic or enduring AoB agreement, provided the agreement covers the practitioner, patient and service being provided.

If an **episodic AoB agreement** is used:

- The agreement can be completed before or after the home visit.
- The agreement must cover the service being provided.
- A new agreement may be needed for future home visits, depending on what services are covered by the original agreement.

If an **enduring AoB agreement** is used:

- The home visit must fall within the scope of the enduring agreement.
- For MyMedicare patients, the service must be provided by the GP named in the agreement and be rendered at or from the patient's registered MyMedicare practice.
- For ACCHO or AMS patients, the service must be provided by a practitioner employed by the ACCHO or AMS and be rendered at or from the practices or clinics covered by the agreement.
- For residents of aged care homes, the service must be provided by the GP named in the agreement and be rendered at or from the residential aged care home or the practice location covered by the agreement.

How do AoB arrangements apply to patients receiving services through the NDIS or DVA programs?

If the service is being funded solely through the NDIS or DVA and no Medicare benefit is being claimed, the AoB requirements do not apply.

8. Pathology and diagnostic imaging

What are the transitional arrangements for pathology?

A 12-month transition period applies to pathology request forms issued before 1 July 2026.

If a pathology request form containing a valid Assignment of Benefit (AoB) was issued before 1 July 2026, that AoB can continue to be relied upon for up to 12 months from the date the request was issued.

Pathology requests issued on or after 1 July 2026 must comply with the updated AoB requirements.

Do GPs need new pathology request forms?

Not immediately.

Existing pathology request forms may continue to be used, provided they include all information required under the new AoB requirements.

If information is missing, it can be:

- added to the existing form; or
- captured through a separate paper or electronic AoB agreement.

Can AoB continue to be collected on a pathology request form?

Yes.

AoB can continue to be collected as part of a pathology request form. A separate AoB agreement is not required, provided the form contains all information required under the current legislation.

For pathology requests issued before 1 July 2026, existing forms may continue to be used under the transitional arrangements.

For pathology requests issued on or after 1 July 2026, practitioners should ensure all required AoB information is collected. This may involve:

- updating an existing request form
- collecting any missing information when the specimen is collected
- using a separate paper or electronic AoB agreement.

In practical terms, most pathology providers can continue using their existing workflows, provided they ensure the required information is collected and retained.

Can AoB be collected on a diagnostic imaging request form?

Yes.

Many practices may find it more efficient to collect AoB on the same form used to request diagnostic imaging services.

Rather than using a separate AoB agreement, the required AoB information can be added directly to the request form.

Using a single document can:

- reduce duplication
- simplify workflows
- create one record for both the imaging request and the AoB agreement.

Practices choosing this approach should ensure the form includes all information required under the AoB requirements and that the completed record is retained appropriately.

Can AoB agreements be collected separately from request forms?

Yes. Practices may choose to use:

- the request form itself
- a separate paper AoB form
- a separate electronic AoB agreement.

The best option will depend on the practice's workflows and software systems.

Regardless of the method used, the patient (or assignor) must be provided with the required information and agree to assign their Medicare benefit before the claim is submitted.

9. Claims, Software and Implementation

Do AoB agreements need to be submitted with bulk bill claims?

No. In most cases, health practitioners are not required to submit AoB agreements to Services Australia when lodging a bulk bill claim.

However, an AoB agreement may be required in certain circumstances, such as manual claiming processes or where supporting documentation is requested by Services Australia.

How do I know if my software is compliant with the new AoB requirements?

The best place to start is with your software vendor.

Ask whether the system has been updated to support the AoB requirements that commenced on 1 July 2026.

Questions you may wish to ask include:

- Does the software support all required AoB information?
- Can it capture electronic signatures or other valid forms of agreement?
- Can completed AoB agreements be retained and retrieved for at least two years?
- Does it support episodic and enduring agreements?
- Has it been tested with relevant Services Australia claiming channels?

While software vendors may provide AoB functionality, health practitioners remain responsible for ensuring they have compliant processes for obtaining, retaining and producing AoB agreements when required.

How will rejected or resubmitted claims be handled?

Services Australia will continue to manage rejected, adjusted and resubmitted claims through existing claiming processes.

Where a claim is resubmitted, practitioners should ensure they continue to hold evidence of a valid AoB agreement that supports the claim.

This is particularly important where an older AoB agreement is being relied upon following the introduction of the new requirements on 1 July 2026.

Are the basic service descriptions available electronically?

Yes. The Department publishes Basic Service Description files on MBS Online in both XML and CSV formats.

These files are intended to help software providers and health practitioners incorporate service descriptions into episodic pre-service AoB agreements.

Basic service descriptions are used in episodic pre-service agreements to describe the service a patient is agreeing to be bulk billed for before the service is provided. Rather than requiring a specific MBS item number to be known in advance, the descriptions group

services into meaningful categories that can be understood by patients while still supporting Medicare claiming requirements.

The Basic Service Description files are updated in line with routine MBS updates, currently occurring on:

- 1 January
- 1 March
- 1 July
- 1 November.

Practitioners using paper-based processes can also access and use the files directly from MBS Online.

What security requirements apply to electronic AoB records?

The legislation does not prescribe a specific software platform, storage solution or technology.

However, AoB agreements must be stored securely, remain complete and legible, and be capable of being retrieved and produced if requested.

This applies whether records are stored electronically or in paper form.

Practitioners should also ensure AoB records are handled in accordance with the *Privacy Act 1988* and any applicable state or territory privacy, health records or records management legislation.

10. Record keeping requirements

What record-keeping requirements apply to AoB agreements?

Health practitioners must keep a copy of each completed AoB agreement for 2 years from the date the Medicare claim is submitted. This requirement applies to all AoB agreements, including:

- paper-based and electronic agreements
- episodic pre-service and post-service agreements
- enduring agreements.

Health practitioners must ensure retained records are complete, accurate and able to be produced if requested as part of Medicare compliance, audit, verification or review activities.

The retained record should include:

- all information required for the relevant type of AoB agreement
- evidence of the patient's or assignor's agreement (for example, a physical signature, electronic signature or another valid record of agreement)
- the date the agreement was made.

Health practitioners must also provide a copy of the completed AoB agreement to the patient or assignor on request.

For enduring agreements, practitioners should also retain records associated with the operation of the agreement, including any notifications provided to assignors where required under the enduring agreement arrangements.

What happens if I cannot produce an AoB agreement when requested?

If you cannot produce a valid AoB agreement, you may be unable to demonstrate that the Medicare benefit was properly assigned.

This could result in compliance activity, including review of the relevant Medicare claims. During the transition period the compliance approach will be consistent with the department's health provider compliance strategy. This will prioritise prevention and education as practitioners work towards adopting new assignment of benefit requirements.

When might Services Australia request an AoB agreement?

Services Australia may request an AoB agreement:

- as part of Medicare compliance activities
- during an audit or verification process
- when reviewing a claim, for example, for post-payment claims adjustment
- where supporting documentation is required for a particular claiming process.

In most cases, AoB agreements are retained by the practitioner and are not routinely submitted with Medicare claims.

Who is responsible for retaining AoB agreements?

The health practitioner who claims the Medicare benefit remains responsible for ensuring AoB agreements are retained and can be produced if requested.

While records may be stored by a practice, healthcare organisation or software provider, responsibility for compliance ultimately rests with the practitioner.

What are the consequences of non-compliance with AoB requirements?

If a practitioner cannot demonstrate that a valid AoB agreement existed, they may be asked to provide further information or supporting documentation.

Non-compliance may result in:

- Medicare compliance activity
- audit or review of claims
- recovery of Medicare benefits where claims cannot be appropriately supported
- other actions available under Medicare compliance arrangements.

In short, practitioners should ensure they can demonstrate that a valid AoB agreement was obtained and retained for every bulk-billed service.

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All information in this publication is correct as at August 2026